State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Exhibit 5

117 CMR 7.00

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117 CMR 7.00: ADMINISTRATION OF ACUTE HOSPITAL UNCOMPENSATED CARE POOL AND CRITERIA FOR CREDIT AND COLLECTION POLICIES UNDER M.G.L. c. 118F AS MOST RECENTLY AMENDED BY St. 1991, c. 495

Section

7.01: General Provisions

(1) Scope, Purpose and Effective Date.

(a) 117 CMR 7.00 implements the provisions of M.G.L. c. 118F, as most recently amended by St. 1991, c. 495, regarding the acute hospital uncompensated care pool.

(b) The purpose of 117 CMR 7.00 is to specify:

1. The rules which will govern payment by hospitals to the pool and payment by the pool to hospitals.
2. The procedures that acute care hospitals must follow regarding the acquisition and verification of patients' financial resource information for determination of patients' ability to pay for hospital care provided and/or to be provided.
3. The criteria that acute care hospitals must meet regarding notification of the availability of free care and public assistance programs to patients.
4. The criteria that acute care hospitals' credit and collection policies must meet regarding bad debt and free care accounts. This shall include, the standards for reasonable collection effort of bad debt accounts; the standards for determining free care accounts; and the standards for documenting bad debt and free care accounts.

(c) 117 CMR 7.00 shall be effective as follows:

1. definitions at 117 CMR 7.02 shall be effective beginning on October 1, 1991;
2. reporting requirements of 117 CMR 7.03 shall be effective for all claims reported for the month of April, 1992 and for all the months thereafter;
3. all other sections of 117 CMR 7.00 shall be effective upon the promulgation of 117 CMR 7.00, unless otherwise specified.
4. 117 CMR 7.02, 7.04(3)(a) and (b), 7.04(4), 7.04(5), 7.04(8) and 7.01(1)(c)(4) shall be effective as of June 4, 1993;
5. 117 CMR 7.11 shall be effective as of October 1, 1993.

(2) Authority: 117 CMR 7.00 is adopted pursuant to M.G.L. c. 118F as most recently amended by St. 1991, c. 495.

(3) Organization: 117 CMR 7.00 is divided into sections. Each section may be further divided into subsections designated by arabic numerals enclosed in parentheses. A subsection may be segregated into divisions, designated by letters enclosed in parentheses. A division may be further segregated into subdivisions designated by arabic numerals followed by a period.

7.02: Definitions

Actual Costs. All direct and indirect costs incurred by a hospital or a community health center in providing medically necessary care and treatment to its patients, in accordance with generally accepted accounting principles.

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Bad Debt. An account receivable based on services furnished to any patient which:
(a) is regarded as uncollectible, following reasonable collection efforts, pursuant to the hospital's credit and collection policies and procedures;
(b) is charged as a credit loss pursuant to the hospital's credit and collection policies and procedures;
(c) is not the obligation of any governmental unit of the federal or state government or agency thereof; and
(d) is not free care.

Charge. The uniform price for each specific service within a revenue center of an acute hospital established in accordance with M.G.L. c. 6B, § 7.

Collection Action. Any activity by which a hospital or its designated agent requests payment for services from a patient or a patient's guarantor. A collection action of a hospital shall include those activities such as preadmission or pretreatment deposits, billing statements, collection follow-up letters telephone contacts, personal contacts and activities of collection agencies and attorneys.

Commission. The Rate Setting Commission established under M.G.L. c. 6A, § 32.

Cost to Charge Ratio. A calculation made pursuant to M.G.L. c. 6B, § 11(4), to be used by the Department of Medical Security in determining the uncompensated care pool's liability to each hospital in accordance with M.G.L. c. 118F, § 15.

Credit and Collection Policy. The hospital's policy, as expressed in a statement of general principles approved by its governing board, guiding the management of the hospital's billing and collection of accounts receivable, and the hospital's procedures, as expressed in an operating plan to implement such policy, with respect to:
(a) the effort the hospital makes to collect payment for services;
(b) the criteria the hospital uses to assign uncollectibles to bad debt account; and
(c) the criteria the hospital uses for the provision of free care. The credit and collection policy shall include, as a minimum, the methods the hospital uses, the practices it follows and the forms or schedules it adopts in order to comply with the Department's criteria and standards for credit and collection policy as set forth in 117 CMR 7.00.

Department. The Department of Medical Security established under M.G.L. c. 118F.

Disproportionate Share Hospital. Any acute hospital that exhibits a payer mix where a minimum of 63% of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act, other government payers and free care.

Emergency Aid to the Elderly, Disabled and Children (EAEDC) Patient. A patient who is a recipient of governmental benefits under M.G.L. c. 117A *et seq.*

Emergency Care. Emergency care shall include hospital services provided after sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain in which the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part, examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd). In order to qualify as emergency care, services must be medically necessary services and must be:

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(a) determined to be an emergency by a medical professional in charge of the patient, and are so classified in the patient's hospital record pursuant to hospital's manual or document described in 117 CMR 7.03(1)(b); or
(b) inpatient medical care services which are associated with and follow immediately the emergency care as described in 117 CMR 7.02(1); or
(c) screening of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify under 117 CMR 7.02(1), to the extent that such screening is required by law.

Federal Poverty Income Guidelines. The federal poverty income guidelines used as an eligibility criterion by the federal Department of Health and Human Services.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year.

Free care. Any unpaid hospital charges for:
(a) emergency care to uninsured patients, for which the costs have not been collected after reasonable collection efforts; or
(b) medically necessary services to patients who are exempt from collection action pursuant to 117 CMR 7.08 and who have been deemed, pursuant to the hospital's credit and collection policy, financially unable to pay for all or part of the hospital care rendered to the patient; or
(c) medically necessary services to patients in situations of medical hardship where major expenditures for health care have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services will be unpaid;
(d) any unpaid charges for services rendered to participants in the Medicare program shall not be deemed free care charges eligible for payment from the pool except to the extent that such charges
1. satisfy the requirements of 117 CMR 7.02: Free care(a) and (b), and
2. were properly submitted for payment to the Medicare intermediary and were rejected by such intermediary as failing Medicare substantive rules.

Gross Patient Service Revenue. The total dollar amount of hospital's charges for services rendered in the fiscal year.

Guarantor. A person or group of persons who assumes the responsibility of payment of (all or part of) the hospital charges for services, but not including third party payers.

Health Insurance Company. A company as defined in M.G.L. c. 175, § 1, which engages in the business of health insurance.

Health Insurance Plan. The medicare program or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization.

Health Maintenance Organization. Company which provides or arranges for the provision of health care services to enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum as further defined in M.G.L. c. 176G, § 1.

Healthy Kids. A program of preventive pediatric health care services for certain children, from birth to age six, administered by the Department pursuant to M.G.L. c. 118F, § 17A.

Healthy Start. A program of health care, designed to lower the infant mortality rate, administered by the Department of Public Health pursuant to M.G.L. c. 111, § 24D.

Hospital. An acute hospital.

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Hospital Service Corporation. A corporation established for the purpose of operating a nonprofit hospital service plan as provided in M.G.L. c. 176A.

Managed Health Care Plan. A health insurance plan which provides or arranges for, supervises and coordinates health care services to enrolled participants, including plans administered by health maintenance organizations and preferred provider organizations.

Medicaid Program. The medical assistance program administered by the department of public welfare pursuant to M.G.L. c. 118E and in accordance with Title XIX of the Federal Social Security Act.

Medical Assistance Program. The medicaid program, the Veterans Administration health and hospital programs and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

Medical Hardship. A situation in which major expenditures for health care and/or income loss stemming from an individual's medical condition have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that he or she will be unable to pay for needed medical services, as described in a hospital's credit and collection policy.

Medical Service Corporation. A corporation established for the purpose of operating a nonprofit medical service plan as provided in M.G.L. c. 176B.

Medically Necessary Service. A service that is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endangers life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include:

(a) nonmedical services, such as social, educational, and vocational services;
(b) cosmetic surgery;
(c) canceled or missed appointments;
(d) telephone conversations and consultations;
(e) court testimony;
(f) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and
(g) the provision of whole blood; provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

Medicare Program. The medical insurance program established by Title XVIII of the Social Security Act.

Provider. Any person, corporation, partnership, governmental unit, state institution and other entity qualified under the laws of the commonwealth to perform or provide health care services.

Private Sector. As defined by the regulations of the Commission.

Private Sector Charges. Gross patient revenues based on all charges to purchasers and third party payors, including charges under MGL c. 152, exclusive of charges for services to publicly aided patients, charges under Titles XVIII and XIX, free care, reduced by all income, recoveries and adjustments, and bad debt, reduced by all income, recoveries and adjustments.

Publicly Aided Patient. A person who receives hospital care and services for which a governmental unit is liable in whole or in part under a statutory program of public assistance.

Purchaser. A natural person responsible for payment for health care services rendered by a hospital.

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Self-Insurance Health Plan. A plan which provides health benefits to the employees of a business, which is not a health insurance plan, and in which the business is liable for the actual costs of the health care services provided by the plan and administrative costs.

Shortfall Amount. The amount equal to the difference between the total allowable free care costs for all hospitals and the revenue available for reimbursement of free care to the hospitals.

Total Patient Care Costs. Patient care cost as reported by the hospital pursuant to the instructions of the Department.

Uncompensation Care. The sum of bad debt and free care.

Uncompensated Care Percentage. The ratio of each individual hospital's private sector charges for the fiscal year to the total of all hospitals' private sector charges for such fiscal year.

Uncompensated Care Percentage. As defined and calculated pursuant to M.G.L. c. 6B, § 11(2).

Uninsured Patient. A patient who is not covered by any of the following:

(a) a health insurance plan including the medicare program or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization; or

(b) a self insurance health plan including a plan which provides health benefits to the employees of a business, which is not a health insurance plan, and in which the business is liable for the actual costs of the health care services provided by the plan and the administrative costs; or

(c) a medical assistance program including the medicaid program, the Veterans Administration health and hospital program and any other assistance program operated by a governmental unit for persons categorically eligible for such program.

A patient shall not be deemed uninsured if such patient has a policy of health insurance or is a member of a health insurance or benefit program which requires such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures.

7.03: Reporting Requirements

(1) Required Reports and Filing Dates. Each acute care hospital shall comply with the following reporting requirements:

(a) DMS Form UC-92 due no later than 45 days after the last day of the fiscal month for which the report is being submitted;

(b) Its manual or any document, in whatever form, setting forth the hospital's classification of persons presenting for unscheduled treatment, the urgency of treatment associated with each such classification, the location or locations at which such patients might present themselves and any other relevant and necessary instruction to hospital personnel who routinely see patients presenting for unscheduled treatment regarding said classification system. The manual or document must list those classifications which qualify as emergency care under 117 CMR 7.00. Such manual or document must be filed with the department by May 15, 1992. Any subsequent amendments thereto shall be filed with the department at least 60 days prior to the effective date of the amendment. Such manual or document must be accepted for filing by the department before it is relied upon by the hospital in claiming any payment from the pool for emergency care;

(c) Its credit and collection policy, as defined by 117 CMR 7.02. The policy which has been filed pursuant to 117 CMR 2.03 shall satisfy the requirements of 117 CMR 7.00. Any subsequent amendments thereto shall be filed with the Department at least 60 days prior to the effective date of the amendment;

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(d) Each acute hospital shall, upon request, file in a format specified by the Department, information regarding its bad debt write-offs and free care write-offs. This information may include, but shall not be limited to: for inpatient accounts, type of write-offs (*i.e.* bad debt or free care), billing number, medical record number, date of admission and/or date of discharge, total amount of charges and amount of charges written off; for outpatient services, type of write-off, billing number, medical record number, date of service, type of outpatient service, total amount of charges and amount of charges written off. Each acute hospital shall, upon request, provide the Department or its agent with access to patient account records and related reports for the purpose of abstraction by the Department or its agent of additional data elements beyond those specified above;

(e) Each acute hospital shall file or make available information which is required by 117 CMR 7.03 or which the Department deems reasonably necessary for implementation of 117 CMR 7.00 in accordance with time limits set forth in 117 CMR 7.03, or within 15 days from the date of request from the Department, unless a different time is specified in the request. The Department may, for cause, extend the filing date for the submission of reports, schedules, reporting forms, budgets, information, books and records. Any request for an extension must be made in writing and submitted to the Department in advance of the filing date.

(2) Enforcement of Reporting Requirements. If a hospital fails to meet the reporting requirements of 117 CMR 7.03(1), the Department may determine that the hospital does not incur any free care expenses for the period for which it fails to meet the reporting requirements. If the Department makes such a determination it will adjust the hospital's liability to or from the uncompensated care pool as calculated pursuant to 117 CMR 7.04 to reflect this determination.

7.04: Payments to and From the Uncompensated Care Pool

Each acute hospital shall make payments to or receive payments from the uncompensated care pool in accordance with 117 CMR 7.04.

(1) Payments to the Department or its agent shall be made in accordance with instructions from the Department.

(2) If any part of the hospital's payment is not made on the due date, the Department shall assess a 5% surcharge on the amount that is overdue. The Department shall reduce this surcharge to 1% of the amount that is overdue if the hospital satisfies and documents the following conditions:

(a) The hospital has applied for and been denied a sufficient working capital loan by a qualified lending institution within the past 90 days; and

(b) The amount overdue exceeds 2% of the hospital's average monthly revenues for the prior six months. The hospital must apply for such surcharge reduction within 15 days of receiving the initial assessment of the surcharge, and must document the above conditions within 60 days of receiving the initial assessment of this surcharge.

(3) Gross Payments to or from the Uncompensated Care Pool. Each hospital's payments to and from the uncompensated care pool shall be based on gross liability to and from the uncompensated care pool. The Department will determine the gross liability of a hospital to or from the uncompensated care pool as follows:

(a) The hospital shall make a payments of its gross liability to the uncompensated care pool in accordance with the invoices from the Department. The Department shall make the appropriate gross payment from the uncompensated care pool to the hospital.

(b) The hospital's fiscal year gross liability to the uncompensated care pool shall be calculated as follows:

1. for the time period of October 1, 1991 to September 30, 1992, inclusive, it will be as set forth in St. 1991, c. 495, § 54;

2. for the time period beginning on October 1, 1992, it will equal the product of each hospital's uncompensated care percentage and the private sector liability to the uncompensated care pool, determined by the general court.

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(c) Pool's gross liability to the hospital shall be determined as follows:

1. pool's gross liability to each hospital shall be equal to the total allowable free care costs of the hospital less the pool shortfall allocation;

2. the total allowable free care costs shall be the product of the cost to charge ratio and the gross free care charges less free care income, related bad debt recoveries and audit results. Gross free care charges shall not include any sums attributable to free care for which reimbursement is available from other sources including, but not limited to, the medicare program, irrespective of whether such reimbursement has been collected by a hospital. Medicare free care shall be considered reimbursable by the pool to the extent allowed by 117 CMR 7.02;

3. the pool shortfall allocation shall be the lesser of the product of the ratio of the hospital's total patient care costs to the total patient care costs of all hospitals, multiplied by the shortfall amount or the amount equal to the total allowable free care costs of the hospital.

(d) If a hospital is unable to determine the appropriate segregation of bad debt related to emergency care from the bad debt related to non emergency bad debt for any fiscal year, then the Department shall make an appropriate estimate. If a hospital is unable to determine recoveries, the Department shall estimate the amount of recoveries of bad debt which is attributable to bad debt arising from the emergency care to uninsured patients on the basis of the ratio of the total of the bad debt recoveries to the total of the bad debt.

(4) Interim Calculation of a Hospital's Payment to or from the Uncompensated Care Pool. In order to facilitate timely payments to and from the uncompensated care pool, the Department will from time to time calculate each hospital's payment to and from the uncompensated care pool for a fiscal year by estimating its liability to and from the uncompensated care pool and crediting any payments made to and from the uncompensated care pool for the fiscal year in question. The calculation shall be made according to the following guidelines:

(a) The Department shall notify each hospital of the methodology used to calculate payments and the results of the calculation for the hospital;

(b) If a hospital has not reported data required to calculate the hospital's net payment, the Department may substitute for the required data elements relevant industry averages, prior year reports by the hospital, or other data the Department deems appropriate;

(c) The Department shall adjust payments to reflect the availability of funds;

(d) The Department may adjust payments to reflect uncompensated care pool expenses for activities authorized in M.G.L. 118F, § 15.

(5) Final Calculation of a Hospital's Payment to and from the Uncompensated Care Pool. The final settlement between the uncompensated care pool and a hospital for a fiscal year shall comply with the guidelines set forth in 117 CMR 7.04(4) and it shall be as follows:

(a) It shall take place upon completion of the relevant audit and calculations by the Department and the commission, for that fiscal year;

(b) It shall be determined using actual gross patient service revenues, final cost to charge ratios and actual free care charges, each having been adjusted for any audit findings;

(c) It shall include reconciliation of any interim payments and estimated liabilities to and from the uncompensated care pool.

(6) Special Calculation for the Settlement Between the Hospitals and the Pool for the Fiscal Year of October 1, 1991 to September 30, 1992. In order to facilitate timely settlement of payments to and from the pool and to promote fair distribution of pool funds among the participating hospitals, the Department will, for the time period of October 1, 1991 to September 30, 1992, determine the gross free care charges eligible for reimbursement before adjustment as follows:

(a) For the time period of October 1, 1991 to March 31, 1992, for those hospitals which are not able to determine the amount of bad debt arising from emergency care to the uninsured, the estimate of the amount of the free care charges eligible for reimbursement before adjustment shall be calculated pursuant to the following rules and formulas:

1. the time period of October 1, 1991 to March 31, 1992 shall be designated as "P1";

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2. the time period of April 1, 1992 to September 30, 1992 shall be designated as "P2";
3. the free care charges as reported on the form UC-92 (less all income, recoveries and adjustments attributable thereto) shall be designated as "FC";
4. the free care charges as reported on the form UC-92 which are attributable to bad debt arising from emergency care to uninsured patients shall be designated as "EBD";
5. the total bad debt charges as reported on the form UC-92 shall be designated as "BD";
6. the uncompensated care for any period shall be the sum of FC for such time period and BD (less all income, recoveries and adjustments attributable thereto) for such time period and shall be designated as "UC";
7. The ratio of EBDP2 to the sum of FCP2 and BDP2 shall be multiplied by UCP1. This product will be the gross free care charges which are eligible for reimbursement.

(b) For the time period of April 1, 1992 to September 30, 1992 for all hospitals and for the time period October 1, 1991 to March 31, 1992, if such reporting is refiled, for hospitals which are able to specifically segregate bad debt arising from emergency care to the uninsured for the time period October 1, 1991 to March 31, 1992, the free care charges as reported on form UC-92 less all income, recoveries and adjustments attributable thereto, shall be the gross free care charges which are eligible for reimbursement.

(7) Reimbursement of Physicians for the Cost of Free Care. Any hospital which has the status of a disproportionate share hospital pursuant to 114 CMR 36.10 and which receives payments from the uncompensated care pool, and such payments are based upon a calculation of the cost to charge ratio which includes, provides for, or has an allowance, calculated by the Commission, for the cost of free care provided by physicians at such hospital, shall use that portion of the uncompensated care pool payments which is attributable to such cost to reimburse such physicians for such free care.

(8) Updates and Final Settlements. The department may calculate all updates and make final settlements with hospitals on a net basis. The net shall be the hospital's gross liability to the uncompensated care pool, as determined pursuant 117 CMR 7.04(3)(b), minus the uncompensated care pool's gross liability to the hospital, as determined pursuant to 117 CMR 7.04(3)(c). If the difference is positive, then that amount shall be the hospital's net liability to the uncompensated care pool; if the difference is negative, then that amount shall be the net liability of the uncompensated care pool to the hospital.

7.05: Administrative Review and Adjudicatory Proceeding

(1) Administrative Review. A hospital aggrieved by any action or failure to act by the department may file an appeal pursuant to the provisions of M.G.L. c. 6A, § 36 or it may seek a review pursuant to the provisions of 117 CMR 7.05.

(2) Administrative Review by the Department. Within 21 days after receiving notice of the Department's determination of a hospital's net payment to or from the pool pursuant to 117 CMR 7.04(5), the hospital may request administrative review of the determination. The scope of this administrative review is to consider whether the Department's determination contains any technical errors in the calculation itself or in the data used for the calculation. This administrative review will not consider issues relating to the validity of 117 CMR 7.05 or the methodology contained in the regulations for determining a hospital's net payment to or from the pool. Such issues may be raised in a request for judicial review filed pursuant to M.G.L. c. 30A, § 7.

(a) Request for Administrative Review. The hospital's request for administrative review must be submitted in writing to the Commissioner of the Department. The request must describe the technical errors and any necessary corrective actions. If a hospital's request for administrative review does not contain the required information and materials, the Commissioner shall notify the hospital, in writing, that the hospital has ten days from the date of the notice to supply the missing information or materials. If the hospital fails to supply the missing information or materials identified by the Commissioner, the Commissioner shall deny the hospital's request for administrative review.

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(b) Administrative Review Process and Decision. Upon receipt of request for administrative review containing the required information, the Commissioner shall refer the matter to the Deputy Commissioner or other designated employee of the Department for review and decision. The Deputy Commissioner or other designated employee of the Department will review the information and materials supplied by the hospital and may meet or otherwise hold discussions with hospital representatives to clarify certain information. After completing this review, the Deputy Commissioner or other designated employee of the Department will issue a

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written decision on the hospital's request. The decision will state whether or not any adjustment to the Department's determination of net payment to or from the pool will be made and will give a brief explanation of the reasons for this decision. When such a decision is issued with respect to a calculation made after a hospital's fiscal year has ended and using the hospital's actual audited data for that fiscal year, the decision shall constitute a Notice of Agency Action and shall contain the notice and other information related to adjudicatory proceedings set forth in 801 CMR 1.02(6).

(3) Adjudicatory Proceedings.

(a) Submission of Claim for Adjudicatory Proceeding. Within 21 days of receiving a Notice of Agency Action described in 117 CMR 7.05(2)(b), the hospital may submit to the Commissioner of the Department a Claim for Adjudicatory Proceeding to resolve any legal and factual issues raised during any administrative review(s) for that fiscal year. A Claim for Adjudicatory Proceeding must be submitted in writing, must identify the issues of law and fact in dispute between the hospital and the Department, and must describe the evidence presented during administrative review to support the hospital's position. A Claim for Adjudicatory Proceeding cannot raise issues of law or fact and cannot cite evidence that were not considered during administrative review.

(b) Disposition of Claim for Adjudicatory Proceeding. The Commissioner or his designee shall review a Claim for Adjudicatory Proceeding together with the related administrative review decision(s) and any materials in the Department's files related to those administrative review decision(s). If the Commissioner or his designee determines, after the review, that there are no genuine issues of material fact and no issues of law in dispute between the hospital and the Department, the Commissioner shall issue an order dismissing the Claim for Adjudicatory Proceeding, and this order shall constitute a final decision of the Department subject to judicial review under M.G.L. c. 30A, s. 14. If the Commissioner or his designee determines, after this review, that there are genuine issues of material fact in dispute between the hospital and the Department, the Commissioner shall issue an order referring the matter to an independent hearing officer designated by the Commissioner to conduct an adjudicatory proceeding in accordance with 801 CMR 1.02 et seq. If the Commissioner or his designee determines, after this review, that only legal issues are in dispute between the hospital and the Department, the Commissioner or his designee may issue an order referring the issues to an independent hearing officer designated by the Commissioner to conduct adjudicatory proceedings pursuant to 801 CMR 1.02 et seq., or the Commissioner or his designee may decide the issues after giving both the hospital and the Department reasonable notice and an opportunity to be heard on these issues. A decision on legal issues by the Commissioner or his designee shall constitute a final decision of the Department subject to judicial review under M.G.L. c. 30A, s. 14.

(c) Conduct of Adjudicatory Proceeding. An adjudicatory proceeding referred to an independent hearing officer designated by the Commissioner shall be governed by 801 CMR 1.02 and 1.03. Such a proceeding also will be governed by the following rules and procedures:

1. An adjudicatory proceeding will address only those issues identified in the Commissioner's order referring the matter to an independent hearing officer.

2. The hearing officer will only consider evidence that was presented to the Department during administrative review, except in those extraordinary circumstances where the hospital can demonstrate that the evidence could not have been obtained or produced at the time of the administrative review.

3. Upon conclusion of the adjudicatory proceeding, the hearing officer will prepare and forward to the Commissioner or his designee a written, recommended decision of the Department. The recommended decision will address each of the issues cited in the Commissioner's order referring the matter to the hearing officer. The Commissioner or his designee may adopt, modify or order reconsideration of the hearing officer's recommended decision.

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4. The Commissioner will issue the final decision of the Department subject to judicial review under M.G.L. c. 30A, s. 14.

7.06: Criteria for Acquisition and Verification of Financial Information from Patients or Patient Guarantors

(1) General.

(a) 117 CMR 7.06 specifies the criteria that a hospital's Credit and Collection Policy must meet regarding the acquisition and verification of financial information from the patient and/or the patient guarantor in order to assess the ability of the patient or the patient guarantor to pay for hospital services.

(b) The Credit and Collection Policy shall specify the procedures for obtaining patient financial information; the procedures for verifying patient supplied information; and the projected completion time for the verification activities.

(2) Minimum Requirements for Patient Supplied Information. The patient supplied information shall include, but shall not be limited to, the patient's name and address, the guarantor's (if any) name and address, the source of any available payment and the amount of such payment.

(3) Inpatient Services.

(a) Non-Emergency Admissions. The hospital shall make reasonable efforts, prior to the date of the patient admission, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(b) Emergency Admission. The hospital shall make reasonable efforts, after the patient is admitted and as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(c) Requirements for Obtaining Additional Information During the Patient's Hospital Stay.

1. The hospital shall make reasonable efforts to contact the relatives, friends and guarantor and the patient for additional information while the patient is in the hospital.

2. The hospital shall identify the department that is responsible for obtaining the information from the patient, and explain the clinical approval process, if any, required in contacting the patient for additional information. If no clinical approval process is required prior to contacting patients, the Credit and Collection Policy must so specify.

(d) Requirements for Obtaining Information at the Time of the Patient's Discharge. If a hospital has not obtained sufficient patient financial information to assess the ability of the patient or the patient guarantor to pay for hospital services prior to the date of discharge, the hospital shall attempt to obtain the necessary information at the time of the patient's discharge.

(4) Outpatient Services.

(a) Non-Emergency Service. The hospital shall make reasonable efforts, prior to treatment, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(b) Emergency Service. The hospital shall make reasonable effort, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(5) Verification of Patient Supplied Information.

(a) Inpatient. The hospital shall make reasonable efforts to verify the patient supplied information prior to the patient discharge. However, the verification may occur at any time during the provision of services, or at the time of the patient discharge or during the collection process.

(b) Outpatient. The hospital shall make reasonable efforts to verify patient supplied information at the time the patient receives the services. The verification of patient supplied information may occur at the time the patient receives the services or during the collection process.

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7.07: Criteria for Assisting Patients Who Have Limited Financial Resources

117 CMR 7.07 specifies the criteria that a hospital's Credit and Collection Policy must meet regarding the assistance of patients and/or patient guarantors with limited financial resources.

(1) Deposit Plan.
(a) The hospital shall not require pre-admission and/or pretreatment deposits for patients who require emergency services.
(b) The hospital shall not require pre-admission and/or pretreatment deposits for patients with family income equal to or less than 200% of the Federal Poverty Income Guidelines.
(c) If hospitals require a pre-admission and/or pretreatment deposit for patients other than those described in 117 CMR 7.07(1)(a) and (b), the Credit and Collection Policy shall describe the method the hospital uses for establishing the amount of the deposit, and the document(s) required to verify the patient supplied information.

(2) Payment Plan.
(a) The hospital shall not require any payment plan for patients who are fully exempt from collection action pursuant to 117 CMR 7.08.
(b) A hospital's Credit and Collection Policy shall specify the hospital's policy regarding payment plans, including the methods for establishing patient liability, the information required from patients to establish payment ability, and the procedures used and the document(s) required to verify the patient supplied information.

(3) Deferred or Rejected Admissions.
(a) A hospital shall not defer or reject admission of patients who are recipients of governmental benefits under M.G.L. c. 117A et seq. (EAEDC) solely due to financial considerations.
(b) If a hospital wishes to defer or reject admission of other patients solely due to financial considerations, its Credit and Collection Policy shall specify the policies and procedures used for such decisions. In all instances, the reasons for deferral or rejection, and the clinical approval or acknowledgement of such deferral or rejection shall be documented.

7.08: Criteria for Identification of Populations not Requiring Collection Action

117 CMR 7.08 specifies the criteria for identifying those populations which shall not be subject to collection action as defined pursuant to 117 CMR 7.02. by setting a minimum free care eligibility standard. 117 CMR 7.08 also governs the criteria the Credit and Collection Policy must meet regarding the determination of patients exempt from collection action.

(1) General Requirements.
(a) All free care provided shall be accompanied by an application for free care signed by the patient, relative or legal guardian. Each application for free care must state, in part, the following:--"I authorize you to release any information acquired in the course of my examination or treatment to the Department of Medical Security or its designee."
(b) There shall be no residency requirements for patients who are residents of the Commonwealth of Massachusetts. If a hospital does not have such requirements for out of state patients the Credit and Collection Policy must so specify.
(c) The hospital or its agent shall not seek legal execution against the personal residence or automobile of patients or guarantors with family income in excess of 200% of the Federal Poverty Income Guidelines, without the express approval of the hospital's Board of Trustees on an individual case by case basis.
(d) The hospital shall not bill patients who are recipients of governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, certain participants of the Department's Healthy Kids program, or the participants in the Department of Public Health's Healthy Start program or of the Department's CenterCare program. The Department shall issue periodic notices to the hospitals regarding billing of the participants in the Healthy Kids program. However, the hospital may initiate billing for a

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